APPENDIX VI

Form of application for claiming refund of medical expenses incurred in connection with Medical Attendance and / or Treatment of Government

NB: Separate form should be used for each patient

1. Name and Designation of the Government Servant with Department (In BLOCK LETTERS)
2. Actual Residential Address
3. Pay
4. Place at which Patient fell ill
5. Name of the patient and his/her relationship to the Government Servant (in the case of children state age also)
6. Amount of Consultation Fee charged by the Authorised Medical Attendant for treatment of the Government Servant at residence under Rule 3(2)(ii)(f) (mention name of the doctor) and attach the prescribed certificate
7. Fee paid to Compounder / Nurse for administering injection at residence of Government servant (attach the prescribed certificate)
8. Ambulance charges
9. Cost of medicines purchase from the market

Sr no	Cash Memo no & date	Name of the Shop	Name of medicine	Amount
1				
2				
3				
4				

10. Other charges admissible under Rules, if any
11. Total amount claimed
12. List of enclosures
    1
    2
    3
    4

Declaration to be signed by the Government Servant

I hereby declare that the statement in this application are true to the bestn of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependent upon me.

I also declare that the claim for these medicines purchased by me has not been presented and drawn in the past.

Date..........

Signature & Designation of the Government Servant and office to which attached

APPENDIX VII

ESSENTIALITY CERTIFICATE

I certify that Mrs. / Mr. / Miss………………………………………wife /son /daughter of Mr. ………………….. employed in the office of…………………………..has been under treatment at / Hospital / Indoor / Outdoorm in my consulting room and that the undermentioned medicines prescribed by me in this connection are essential for the recovery / prevention of serious deterioration in the condition of the patient. These medicines are not stocked in the.......................................for supply to private patient and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available or preparations which are primarily foods, toilets or disinfectant.

	Cash memo no. & date	Name of medicines	Cost
1			
2			
3			
4			
5			
6			
7			

Signature & Designation of Authorised
Medical Attendant

Signature of the Authorised Medical
Officer i/c of the case in the hospital

2. Certified that the patient is / was suffering from…………………………….. Disease and is / was under my treatment from……………….to………………It is further certified that the disease mentioned above does not under venereal disease, Delerium / Tremens.
3. The patient did not require / required hospitalisations. The case is/ was definitely not / one of prolonged treatment.
4. Certified that the treatment is over / continuing.

Entered at serial no……………………. in Hospital / Dispensary Register on……………………(Date)….

Signature of the Authorised
Medical Attendantl

Place…………….

Signature of the Authorised Medical
Officer i/c of the case in the hospital

Date……………….